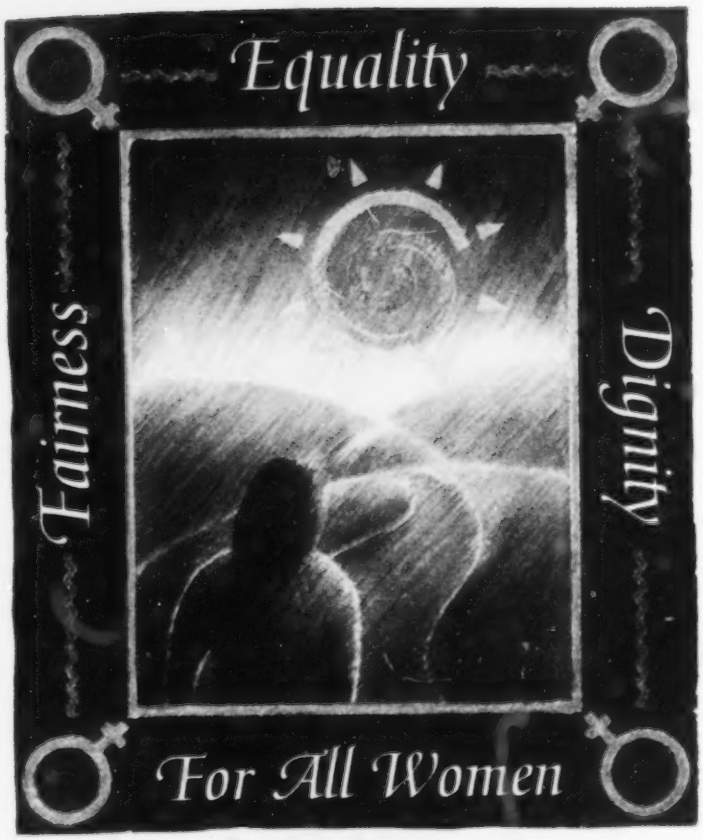
Nova Scotia
Advisory Council on
The Status of Women

Conseil consultatif sur la
condition féminine de la
Nouvelle-Écosse

An agency of the Province of Nova Scotia

Gender and HIV/AIDS
A Backgrounder

September, 2003



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Nova Scotia Advisory Council
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About the Council...

The Nova Scotia Advisory Council on the Status of Women was established by provincial statute in 1977. The Council's mandate under the Advisory Council on the Status of Women Act is to advise the Minister Responsible for the Status of Women and to bring forward the concerns of women in Nova Scotia.

The Council's work touches on all areas of women's lives, including...

- ♀ family life
- ♀ economics
- ♀ legal rights
- ♀ sexuality
- ♀ health
- ♀ education
- ♀ paid and unpaid work
- ♀ violence

Council pays close attention to the experiences of women who face barriers to full equality because of race, age, language, class, ethnicity, religion, ability, sexual orientation, or various forms of family status.

We are committed to voicing women's concerns to government and the community through policy research, information services and community liaison. Working cooperatively with women and equality-seeking organizations, our mission is to advance equality, fairness and dignity for all women.

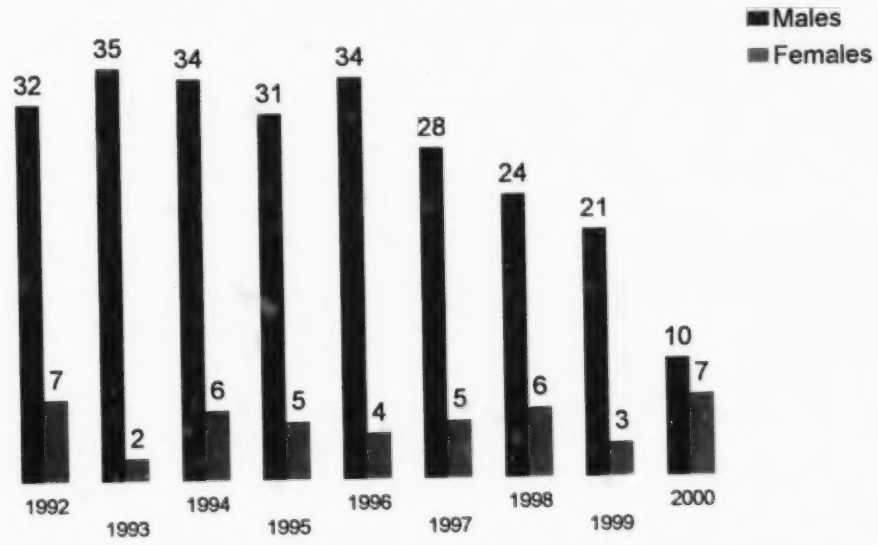
Gender and HIV/AIDS

National level statistics indicate that rates of HIV/AIDS[1] among women in Canada are increasing over time. Prior to 1992, women accounted for 5.6% of AIDS cases in Canada. By 1995, women comprised 8.3% of AIDS cases and in 2001, women accounted for 16% of reported AIDS cases, nationally.

As it can take ten years or more between initial infection with HIV and the development of AIDS, it is important to look at HIV statistics to get a sense of more recent infections. Prior to 1995, women accounted for just under 10% of all positive HIV reports. Between January, 1999 and the end of December, 2001, the proportion of positive reports among Canadian women rose significantly, to nearly 25%[2].

Trends related to HIV/AIDS are more difficult to establish in the Nova Scotian situation as the number of reported cases is relatively small and these are based on the province where testing took place and do not account for movement/migration. Overall, as is the case with the rest of Canada, the total number of cases of new HIV infections has gone down since the mid '80s. Although the number of positive HIV tests in Nova Scotia remains low (there were 17 positive HIV tests in Nova Scotia in 2000 and 13 in 2001), the most recent gender-disaggregated statistics indicate that the ratio of HIV infected women to men was greater (7 to 10) in 2000 than in past years[3].

Number of HIV-Positive Tests by Sex
Nova Scotia, 1992 to 2000

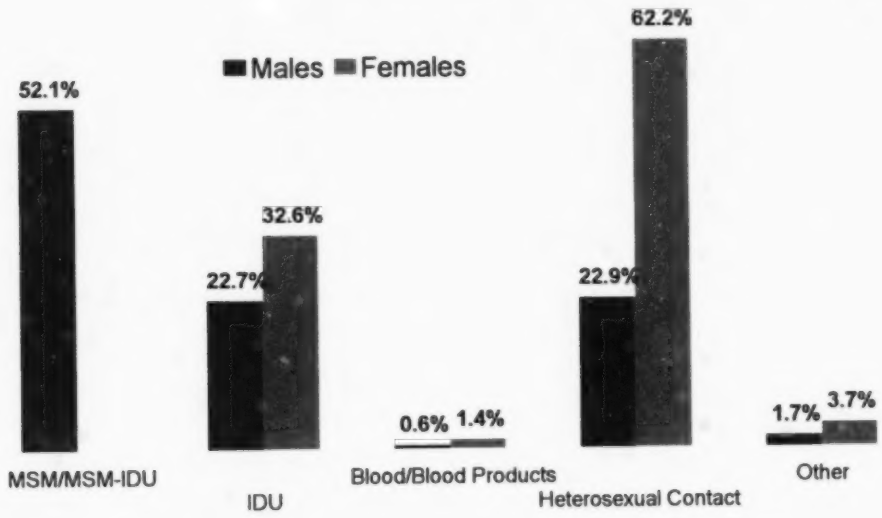


Source: Province on Nova Scotia and Bureau of HIV/AIDS, STD and TB, CIDPC, Health Canada

In Canada, a total of 6,713 females and 38,965 males have tested positive for HIV between 1985 and 2002. Of these, 76 females and 491 males were tested in Nova Scotia.

For Canadian women, heterosexual contact with an infected male partner remains the primary exposure category associated with newly diagnosed HIV infection, though injection drug use (IDU) continues to be a significant risk factor as well.

Positive HIV Tests by Exposure Category and Sex
Canada, 2001



Source: Health Canada, HIV and AIDS in Canada, Surveillance Report to June 30, 2002

Nationally, heterosexual contact with an infected partner was the main risk factor for 62.2% of Canadian women and 22.9% of Canadian men diagnosed with HIV in 2001. IDU was the main risk factor for 32.6% of women and 22.7% of men diagnosed. While there has been a steady decline in recent years in the number of HIV and AIDS cases attributed to MSM (men who have sex with men), this exposure category remained the greatest risk for Canadian males who became HIV positive in 2001. Since HIV testing began in 1985, MSM has accounted for 70.9% of positive HIV tests and 77.6% of cumulative AIDS cases among Canadian adult males.

Women and vulnerability to HIV

There are a number of factors, both physiological and socio-cultural that interact to influence the health of individuals and communities. By examining some of these factors, or determinants of health, we can more clearly understand the ways in which women might be at increased risk for HIV infection.

Until fairly recently, women with HIV were frequently ignored or misdiagnosed by the medical system. Focus groups conducted with HIV+ women in Atlantic Canada as recently as 2000 indicated that physicians tend to dismiss women's HIV concerns, even when risk assessments indicate vulnerability. There have been several reported cases in Atlantic Canada of women not being diagnosed until they had developed AIDS[4]. As

a result of these failings, women have had little or no access to information, treatment, counseling or support in relation to HIV/AIDS and, until recently, were typically excluded from HIV/AIDS research. Late diagnosis and delayed treatment may also partly explain why women have a lower AIDS survival rate than men. With the realization and acceptance by the medical establishment that women were at risk for HIV also came the knowledge that women present with different kinds of symptoms than men, and that they require different kinds of treatment and prevention programs[5].

Biology and genetic endowment

Because of anatomical and physiological differences, it is estimated that women are 2 to 4 times more likely to contract HIV during heterosexual sex than men. HIV is also easier to contract if another sexually transmitted infection (STI) is present. Many STIs go undetected as the infected person may have few, if any, symptoms. Young women aged 15-19 have the highest rates of STI in Canada, resulting in their increased vulnerability to HIV. In 2000, 15-19 year old females in Canada had a rate of genital chlamydia that was more than 5.5 times greater than the rate for 15-19 year old males (1236.1 versus 220)[6]. Of recent concern is the increase in the rates of gonorrhea in Canada as well as this STI's increasing resistance to antibiotic treatment. Researchers suggest that this increase may be due, in part, to evaporating fears of HIV/AIDS and the fact that sexually active youth are unaware of the early devastation caused by AIDS. The interdependent nature of HIV and other STIs only reinforces the need for an inclusive strategy to sexual health, particularly for youth.

HIV, Gender Roles, and Violence Against Women

Traditional gender roles related to sexuality and imbalances in power between the sexes may place women at increased vulnerability to HIV, eg., young women may still find difficulty in negotiating safer sex with male partners. There is still a stigma attached to women being sexually active making access to sexuality information problematic unless it is anonymous.

As most women acquire HIV through heterosexual contact, typically at a young age, ensuring that prevention programs target heterosexual men is imperative. Focusing prevention efforts exclusively on women and their ability to negotiate safer sex is insufficient given that women do not necessarily have control over their male partners' current or past sexual and risk-taking behaviour. Such efforts also serve to reinforce the idea that women alone are to be concerned about and responsible for ensuring safer sex and good sexual health. HIV/AIDS research and prevention efforts need to:

- target heterosexual men specifically
- start addressing some of the imbalances in power that are often part of sexual relationships between men and women, and
- be meaningfully linked with continuing research and prevention efforts targeted at women.

Violence against women and sexual violence remain significant problems in our society and also contribute to women's vulnerability to HIV. Sexual violence, intimate partner violence and concerns about personal safety within communities are realities for many

violence and concerns about personal safety within communities are realities for many women. According to a national survey on violence against women conducted in 1993, 40% of Canadian women have experienced at least one incident of sexual violence since the age of 16[7]. Forced sexual activity can involve unprotected sex and can lead to unintended pregnancy, and sexually transmitted infections, including HIV.

Inequality and HIV

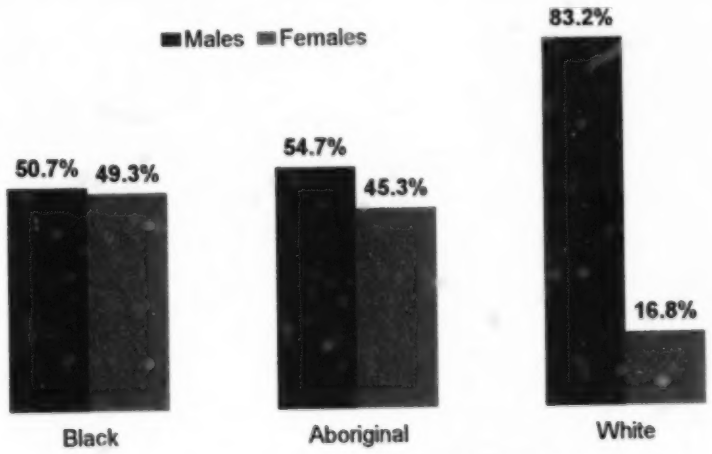
The groups that are most vulnerable to HIV/AIDS in our society are those that are the most marginalized or socially and economically excluded[8].

Numerous economic, social, and cultural factors combine and interact to affect women's vulnerability to HIV/AIDS. Women who are socio-economically and educationally disadvantaged lack access to the basic resources required to stay healthy in our society, whether it be adequate food, housing, transportation, or health services and information.

Women also experience inequality and discrimination in relation to their gender, race, ethno-cultural identity, level of ability, and sexual orientation. Such inequalities serve to reduce the control women have over their health and lives and to greatly limit the choices women have when making decisions about how to lead healthy lives.

This vulnerability can be exemplified by the dramatic differences that exist in the proportion of women testing positive for HIV depending upon their ethnocultural background. Between 1998 and June 30, 2002, females have comprised just under 17% of positive HIV reports among Whites, yet comprise close to half of positive HIV reports among Blacks and Aboriginals (49.3% and 45.3%, respectively) in Canada.

Positive HIV Tests by Ethnic Group and Sex
Canada, 1998 - June 30, 2002



Source: Health Canada, HIV/AIDS EPI Updates, April 2003

Young women and HIV

The proportion of women among positive HIV tests varies substantially depending on age. National level statistics indicate that young women (those aged 15-29) account for the greatest proportion of females who test positive for HIV. In 2000, 15-19 year old females testing positive for HIV outnumbered males of the same age group, by a small margin (ie., females accounted for 51.5% of positive HIV tests among Canadians aged 15-19). In 2001, women accounted for 44.5% of positive HIV test reports among those aged 15-29 years, an increase from 41% in 2000.

Age Distribution of Cumulative HIV+ Tests among Females
Nova Scotia, 1983-2000

Source: Province on Nova Scotia and Bureau of HIV/AIDS, STD and TB, CIDPC, Health Canada

In Nova Scotia, a similar pattern is evident in that more than half (51.2%) of the 76 females who tested positive for HIV in Nova Scotia between 1983 and 2000 were under the age of 30.

Aboriginal Women and HIV

Although Aboriginal persons comprise approximately 3.3% of the Canadian population[9], they accounted for close to 9% of all new HIV infections in 1999. Aboriginal women in Canada have shown particularly large increases in rates of HIV and AIDS in recent years. Currently, Aboriginal women comprise close to half of Aboriginal persons newly diagnosed with HIV compared to 20% of non-Aboriginal women[10]. Most Aboriginal women with HIV are young which raises concerns about the increasing rate of mother-to-infant transmission of HIV. Aboriginal women in Nova Scotia have high rates of poverty (in 1995, more than half of Aboriginal women living on-reserve were earning less than $10,000 per year) and face many barriers to services. Many HIV+ Aboriginal women are single parents who are living below the poverty line. As is the case for many women, the role of caregiver is paramount in the

children's needs are often placed before their own. Mothering/caregiving is central to the lives of women with children and families and addressing this issue when developing treatment and supportive resources for women with HIV/AIDS is therefore imperative.

Lesbians

Women who have sex with women can also be at risk for HIV/AIDS. It is a myth that woman to woman sex is necessarily safe sex. Lesbians and bisexual women can get HIV through sexual contact with an infected male, by needle sharing during injection drug use, and by the exchange of blood and vaginal secretions during sex with other women.

Sex Workers

Women and men who work in the sex trade are also vulnerable to HIV/AIDS but research indicates that there are substantial variations in their level of risk, depending on a number of factors such as the type of sex work, age, and injection drug use[11]. Street workers are more vulnerable as they are more likely to be poor, young, with a history of childhood abuse, and drug or alcohol dependent. They are also much more vulnerable to violence. Injection drug use appears to be a significant HIV risk factor among female prostitutes.

Conclusions

Overall, the number of Canadian women living with HIV/AIDS increased by 48% from 1996 to 1999. Though part of this increase may be due to increased awareness of HIV and an increase in women's HIV testing, part of this increase may also be related to the health systems' past failure to adequately detect HIV/AIDS in women or even to consider the possibility that heterosexual women might be at risk for HIV/AIDS.

It is estimated that the direct and indirect costs of HIV/AIDS cost Canadians more than $2 billion in 1999, with health care costs accounting for $560 million, prevention, research, and support for PHAs (persons with HIV/AIDS) totaling $40 million and lost economic production due to premature death and disability totaling close to $1.5 billion[12]. While the economic costs of HIV/AIDS are significant, the human and social costs are even greater.

It is clear that, while HIV/AIDS research and prevention efforts tend to focus on risk-taking behaviour of individuals, failure to take into account the multitude of barriers (to education, employment, health services, etc.) and the limited choices that exist for some in our society means that we are failing to see and address the social factors underlying HIV/AIDS.

Strong evidence has now been established that social and economic conditions (sexism, racism, poverty) affect women's lives, health and vulnerability to HIV. Clearly, these factors need to be specifically addressed when developing policies and programs to address the needs of women in relation to HIV/AIDS prevention, education, risk reduction, care, treatment, and support.

Groups Vulnerable to HIV/AIDS
How Women and Men are Affected

	Men	Women
Men who have Sex with Men (MSM)	MSM remains the most common way in which males contract HIV/AIDS. Although there have been substantial and steady decreases[13] in the proportion of HIV infections attributed to MSM since the mid-eighties, in 2001, just over half (52.1%) of new HIV infections among males in Canada were attributed to MSM. Factors such as loneliness, isolation and depression, lack of social support, homophobia, and "prevention fatigue" contribute to the vulnerability of this group and may play a role in risk-taking behavior such as unprotected anal intercourse and unsafe sex with a known HIV+ partner. These behaviors, in turn, are linked to MSM's continuing high risk for HIV infection. Renewed and innovative efforts in effective HIV prevention are clearly indicated for this population.	Women are affected by MSM in that a certain proportion of men who have sex with men, also have sex with women (MSMW). In 2001, close to half (49%) of women whose HIV infection was attributed to heterosexual contact had high-risk partners, including bisexual men and IDU. The female sexual partners of MSMW may not be aware of their risk for HIV as MSMW are often highly closeted (ie., are secretive about and have not disclosed their homosexuality) and may not respond to prevention programs aimed at gay men.[14]
	Men	**Women**

Aboriginal Persons Aboriginal persons comprise about 3% of the Canadian population but about 9% of newly diagnosed HIV infections. As the Aboriginal population is younger than the population as a whole, newly infected Aboriginal men and women also tend to be younger. Injection drug use (IDU) is a particularly important HIV risk factor for this group.	Aboriginal men comprise 55% of Aboriginal persons newly diagnosed with HIV (compared to 80% for non-Aboriginal men). Aboriginal men are more likely to become HIV+ through IDU and they are less likely to become HIV+ through MSM than are non-Aboriginal men.	Aboriginal women comprise 45% of Aboriginal persons newly diagnosed with HIV (compared to 20% for non-Aboriginal women). Aboriginal women are more likely to become HIV+ through IDU than are non-Aboriginal women. 64% of Aboriginal women with AIDS (compared to 23% of **all** women with AIDS) can be related to IDU.
Injection Drug Use (IDU) IDU accounts for just over 16% of cumulative HIV+ test reports in Canadian adults. Women, youth (especially if street-involved) and Aboriginal persons who are injection drug users are at particularly high risk for HIV. Research indicates that rates of needle sharing and unprotected sex remain high among both males and females involved in IDU.	The proportion of IDU among HIV+ males has remained steady, around 20-22%, over the past several years. Research reports suggest that between 20 and 30% of males involved in IDU trade sex for money or drugs.	Since 1996, between one third and one half of new HIV test reports among women have been attributed to IDU. Many females who use injection drugs (estimates range from between 50% and 72%) trade sex for money or drugs. The proportion of females involved in IDU who report having unprotected sex is also very high.[15] Risk-taking (on the part of both sexual partners) and females' biological vulnerability during vaginal intercourse combined with the gender imbalances in power that are present in many heterosexual relationships are likely strong causal factors in the high HIV rates among females who use injection drugs.

	Men	Women
Youth (15-29 years) Youth constitute just under 30% of positive HIV tests in Canada reported up to June 30, 2002. Heterosexual contact accounted for 40% of HIV infections in the 20-29 year age range and for 55% of infections in the 15-19 year age range in the first half of 2002. Research suggests that many youth take considerable risks with their sexual health, including having sexual intercourse at an early age, having multiple sexual partners, and having unprotected sex. Research has also shown that there is an association between substance use by youth and unplanned sexual intercourse[16]. Deeply ingrained beliefs about gender roles in relation to sexuality and responsibility for reproductive and sexual health are still very much intact.	A significant proportion of young males (close to 30%) report having multiple sexual partners. As is the case, with females this age, a large proportion of young males engage in unprotected sex. 29% of sexually active males aged 15-19 report "never or only sometimes" using a condom in the past year. The corresponding figure for 20-24 year-olds was 44%[17]. In the first half of 2002, MSM accounted for 40% of positive HIV tests among males aged 20-29.	More than half (51.2%) of females who tested positive for HIV in Nova Scotia between 1983 and 2000 were under the age of 30. Compared to other age groups, the proportion of females among positive HIV tests is highest for youth. In 2001, females accounted for 44.5% of positive tests in this age range, a 41% increase from 2000. One quarter of females aged 15-19 report having had sexual intercourse before the age of 15. Biological and anatomical differences between males and females make females more vulnerable to sexually transmitted infections (STI). Many STIs go undetected and the presence of an STI makes young females even more physiologically vulnerable to HIV infection. The highest rates of chlamydia and gonorrhea are among 15-19 year old females. Chlamydia rates among this age group are 5½ times greater than among males the same age. Rates of STI are not surprising given what research on condom usage among this age group indicates. More than half (51%) of sexually active females aged 15-19 report "never or only sometimes" using a condom during the past year. For 20-24 year-old females, the figure was 53%[17].
	Men	**Women**

Prison Inmates The proportion of prisoners with HIV is approximately 10 times higher than the proportion for the general population of Canadians with HIV.	In 2001, 1.7% of males incarcerated in Canadian prisons were HIV positive.	In 2001, 4.7% of females incarcerated in Canadian prisons were HIV positive.

Notes

1. The human immunodeficiency virus (HIV) is the virus that causes acquired immunodeficiency syndrome (AIDS). HIV positive (HIV+) status refers to the presence of HIV antibodies in the blood, indicating that the person has been exposed to HIV. AIDS is a progressive symptom of HIV and is characterized by specific symptoms and/or diseases. The time between initial infection with HIV and the development of AIDS can be ten years or more. New treatments have increased the life span of people living with HIV/AIDS and improved their quality of life.

The main ways in which HIV is transmitted are:

- through specific sexual activities such as unprotected anal and vaginal intercourse with an infected partner;
- through injection drug use (IDU) by sharing used or uncleaned needles or syringes;
- from mother to child, in the uterus, during childbirth or through breastfeeding.

(Source: Health Canada, Women and HIV/AIDS fact sheet, available on the Internet at: http://www.hc-sc.gc.ca/women/english/facts_aids.htm

2. Gender is not reported for 5,792 HIV tests reported between 1985 and 2002. It is estimated that 15,000 of the 49,800 (30%) Canadians living with HIV at the end of 1999 were unaware of their infection.

3. There are a number of factors which place limitations on the accuracy and completeness of HIV/AIDS surveillance data in Nova Scotia. These include factors like geographic isolation, economic need, and fear of exposure which might affect whether or not someone gets tested for HIV as well as the fact that there is only one anonymous testing site in the province (in metro). The notion of an "accurate" picture of HIV/AIDS infection rates among Canadian women is particularly problematic in that heterosexual women have generally not been targeted for HIV testing outside the pre-natal context.

4. AIDS Coalition of Nova Scotia. (2000). Regional Realities: HIV/AIDS Prevention Education Priority Issues in Atlantic Canada.

5. Health Canada (2002). Women's Health Bureau Fact sheet on *Women and HIV/AIDS*.

6. Division of Sexual Health Promotion and STD Prevention & Control, Bureau of HIV/AIDS, STD & TB, Health Canada, 2001.

7. Source: Statistics Canada, *Violence Against Women Survey*, 1993.

8. Albert, Terry and Gregory Williams, with the collaboration of Barbara Legowski and Dr. Robert Remis, *The Economic Burden of HIV/AIDS in Canada*, CPRN Study No. H02, Renouf

Publishing, 1998, pages 9, 12, and 14.

9. Source: Statistics Canada, 2001 Census, Aboriginal Identity variable.

10. Source: Ship, S.J., and Norton, L. (2002) HIV/AIDS and Aboriginal Women in Canada. In *Striking to the Heart of the Matter: Selected Readings on Gender and HIV*. Edited by Carol Amaratunga and Jacqueline Gahagan, Atlantic Centre of Excellence for Women's Health, 2002.

11. Source: *What are sex workers' HIV prevention needs?*, Center for AIDS Prevention Studies, AIDS Research Institute, University of California at San Francisco.

12. Source: GPI Atlantic, 2001, *The Cost of HIV/AIDS in Canada.*

13. Data suggests that there was an increase in HIV infections among MSM in some areas of Canada in 1999-2000 compared to the preceding years. Source: Health Canada, *HIV/AIDS Epi Update*, April, 2003.

14. Source: Campbell, C.A. (1995). Male gender roles and sexuality: Implications for women's AIDS risk and prevention. Soc. Sci. Med. 41(2), pp. 197-210.

15. Up to 92% of female involved in IDU report having unprotected sex with regular partners and up to 71% report unprotected sex with casual partners. Source: Health Canada, *HIV/AIDS Epi Updates*, April, 2003.

16. Source: Poulin, C., and Graham, L. (2001). The association between substance use, unplanned sexual intercourse and other sexual behaviours among adolescent students. *Addiction* (2001) 96, 607-621.

17. Source: *Nova Scotia Student Drug Use Survey, 2002*, Nova Scotia Department of Health.